DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155327	A. BUILDING _____ B. WING _____	C 01/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY INC	1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00084479. Complaint IN00084479 substantiated, federal/state deficiencies related to the allegations are cited at F514. Survey dates: January 3, 4, 5, 6 & 7, 2011 Facility number: 000220 Provider number: 155327 AIM number: 100267650 Survey team: Marcy Smith RN TC Leia Alley RN Rhonda Stout RN Patti Allen BSW Kristy Landers RN [January 3, 4, 5, 6, 2011] Diane Dierks RN [January 3, 4, 5, 6, 2011] Census bed type: SNF/NF: 132 SNF: 20 Total: 152 Census payor type: Medicare: 31 Medicaid: 97 Other: 24 Total: 152 Sample: 24 Supplemental sample: 2	F 000	This plan of correction is to serve as University Heights Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report is true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. RECEIVED FEB 0 1 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Farrell Rumple — TITLE: Administrator — (X6) DATE: 2/01/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 2 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper and immediate attention to a bruise of unknown origin and failed to complete an immediate and complete investigation for 1 of 21 residents reviewed for assessments in a sample of 24. (Resident #B) Findings included: Resident B's clinical record was reviewed on 1/6/11 at 10:45 A.M. During the tour on 1/3/11 at 10:25 a.m., a large bruise was noted to top of right wrist and right hand of Resident B. The bruise was outlined by black ink. Unit Manager #5 indicated the "...bruise was noted over the weekend and she's had no recent falls. We are investigating." Nurse's notes dated 1/1/11 at 11:00 a.m., indicated "...bruise to res [resident's] R [right] hand...Area measures approx [approximately] 10.7 cm x 11.2 cm. MD [Medical Doctor], DON [Director of Nursing] et [and] family notified. Geri sleeves placed on res [resident]." A facility policy on "INJURY IDENTIFICATION", dated 10/03 and revised 04/06, was reviewed 1/6/11 at 1:25 p.m., indicated "...Injuries of unknown source when not observed by any	F 225	C.N.A. bathing skin care check documentation will be reviewed daily (Monday through Friday) by the Unit Manager or an administrative nurse to determine that appropriate follow up has occurred. Training will be provided to Licensed Nurses on weekly skin checks and to C.N.A.'s on bathing skin care checks on scheduled shower days. This training will also include reporting, communication, and follow procedures for identified bruises. IV. The Director of Nursing and/or designee will review 24 hour nursing report sheets, and scheduled Licensed Nurse weekly skin and C.N.A. bathing skin checks on daily basis (Monday through Friday) as on ongoing practice.	

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F 000	Continued From page 1 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 1-14-11 Cathy Emswiller RN	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	F225-483.13(c)(1)(ii)-(iii)-(c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/ INDIVIDUALS I. Resident #B's right hand bruise is resolving. C.N.A. #8, C.N.A. #10, L.P.N. #11 were educated and counseled regarding policies to immediately report and follow up on any observed bruises. II. Nursing management personnel have completed skin assessments on each resident within the facility to establish baseline evaluation of skin integrity above and beyond Licensed Nurse and C.N.A. current skin care evaluation practices. III. A systemic change will include that all assigned Licensed Nurse weekly and	

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F 225	Continued From page 3 person or explained by the resident will be investigated..." A facility investigation reviewed on 1/6/11 at 2:55 p.m., titled "ACCIDENT INVESTIGATION FORM UNUSUAL OCCURRENCES", not dated, CNA # 8 indicated "I saw the bruise on Wednesday...I didn't tell anybody because I thought it had been there". CNA # 9 indicated "Activities asked me about it on Friday at the New Years Party. I told (Nurse) about it and she replied that (resident) had bruises everywhere." CNA #10 indicated "I have seen a little bruise on her hand, don't recall what day but it was smaller. I thought it had been reported before." LPN # 11 indicated "...One of the CNA's told me about a bruise, but she (resident) always bruises."	F 225	Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion Date: February 6, 2011.	
F 272 SS=D	3.1-28(c) 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		

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F 272	Continued From page 4 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure assessments were done for a dialysis shunt for 1 of 21 residents reviewed for assessments in a sample of 24. (Resident #82) Findings included: The record of Resident #82 was reviewed on 1/6/11 at 8:10 A.M. Diagnoses for Resident #82 included, but were not limited to, end stage renal disease and dialysis. She was admitted to the facility on 5/21/10 and had been receiving dialysis treatments at a local dialysis center on Monday, Wednesday and Friday every week since her admission. A care plan for Resident #82, originating on 5/26/10 and updated 9/16/10, indicated a problem of "Dialysis related to chronic renal failure" and a goal of "Will have no adverse reactions to dialysis	F 272	F272-483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS I. Resident #82's dialysis physician was notified 1/06/11 and orders received clarifying hemodialysis aftercare. Resident #82's dialysis plan of care has been reviewed and updated. A hemodialysis aftercare assessment flow sheet has been initiated to document daily shunt site care (monitoring for symptoms of bleeding and infection). II. The dialysis physician for all current residents receiving hemodialysis was notified and orders received clarifying hemodialysis after care. The dialysis plan of care for all current residents receiving hemodialysis has been reviewed and updated. A	

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F 272	Continued From page 5 process through next review." Approaches/interventions included, but were not limited to: ..."3 Monitor I & O [intake and output]/record...6 Observe shunt site daily for signs and symptoms of infection and bleeding...8 Monitor site for signs of bleeding when returns from dialysis..." Nurses' notes for Resident #82 for November, December, 2010 and January, 2011 did not indicate her shunt site was ever observed for signs of infection. They did not indicate the shunt site was observed for signs of bleeding on November 1 - 29, 2010, December 2 - 8, 11-13, 15, 18, and 28, 2010, and January 2 - 4, 2011. Nurses' notes for November, December, 2010 and January, 2011 did not indicate the shunt site was monitored for signs of bleeding after Resident #82 returned from dialysis on November 3, 5, 8, 10, 12, 15, 17, 19, 22, 24, 26, and 29, 2010, December 3, 6, 8, 13, 15, 2010, and January 3 and 5, 2011. Further information was requested from Licensed Practical Nurse (LPN) #5 on 1/7/11 at 1:00 P.M. regarding the missing assessments of the shunt site for infection and bleeding. On 1/7/11 at 4:00 P.M. LPN #5 indicated no further information was available which indicated assessments of the the resident's shunt site for bleeding and infection were done.	F 272	hemodialysis aftercare assessment flow sheet has been initiated for all current residents receiving hemodialysis to document daily fistula/shunt/or dialysis catheter care (monitoring for symptoms of bleeding and infection). III. A systemic change will include the development and implementation of a hemodialysis aftercare assessment flow sheet. The hemodialysis aftercare flow sheet will be completed every shift by the licensed nurse caring for each residents receiving hemodialysis. Training will be provided to licensed nurses regarding hemodialysis aftercare. This training will also include review of assessment and documentation requirements of the hemodialysis aftercare assessment flow sheet.	
F 279 SS=E	3.1-31(a) 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 6 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the development and timely review of comprehensive care plans for 6 out of 21 residents reviewed for the development and timely review of care plans in a sample of 24. (Resident #111, #48, #B, #117, #66 and #104) Finding included: 1. The record review for Resident #111 was reviewed on 1/4/11 at 1:55 p.m. Diagnoses for Resident #111 included, but were not limited to, atrial fibrillation, coronary artery disease, sick sinus syndrome with pacemaker	F 279	IV. The Director of Nursing and/or designee will review 100% hemodialysis aftercare flow sheets weekly for 6 months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion Date: February 6, 2011.	

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F 279	Continued From page 8 one for a "Diagnosis of Chronic UTI's" (urinary tract infections) originating 5/5/10 and "Resident is frequently incontinent of bowel and bladder" originating 2/9/09. Both of these care plans had been updated on 11/5/10 adding an intervention of "16 FR[ench] Foley catheter." There was no care plan initiated or in place focusing on care of the Foley catheter with interventions to prevent complications for the resident. In an interview with the Assistant Director of Nursing on 1/4/11 at 11:30 a.m. she indicated there was no care plan in place for Resident #48's Foley catheter. 3. The record of Resident #B was reviewed on 1/6/11 at 10:45 a.m. Diagnoses for Resident #B included, but were not limited to, dementia, delusions, and incontinence. A care plan for wandering was dated 9/29/10. A second care plan for incontinence was dated as 7/8/10. The care plans had not been reviewed, revised or updated since. 4. The record of Resident #117 was reviewed on 1/3/2011 at 3:00 PM. Diagnoses for Resident #117 included, but were not limited to, Heat Syncope (fainting due to heat related stress on the body), Anemia, Hypertension, Hypothyroidism, Severe Bilateral Carotid Stenosis. A health care plan problem dated 2/10/2010, indicated Resident #117 had a history of falling related to diagnosis of Heat Syncope. The goal of the care plan was, Resident will remain free from injury. The care plan indicated that there	F 279	F279-483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS I. Resident #111, #B, #117, #66, and #104's comprehensive care plans (inclusive of problem statements, goals and approaches) have been reviewed and updated as necessary. Resident # 48 no longer resides in the community. II. Unit Managers and/or designee and/or other appropriate interdisciplinary team members will review and update each resident's plan of care in conjunction with new physician orders received on daily basis (Monday-Friday). Unit Managers and/or other interdisciplinary team members will construct an initial plan of care (inclusive of problem statements, goals and approaches) focusing on resident's highest priority	

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F 279	Continued From page 8 one for a "Diagnosis of Chronic UTI's" (urinary tract infections) originating 5/5/10 and "Resident is frequently incontinent of bowel and bladder" originating 2/9/09. Both of these care plans had been updated on 11/5/10 adding an intervention of "16 FR[ench] Foley catheter." There was no care plan initiated or in place focusing on care of the Foley catheter with interventions to prevent complications for the resident. In an interview with the Assistant Director of Nursing on 1/4/11 at 11:30 a.m. she indicated there was no care plan in place for Resident #48's Foley catheter. 3. The record of Resident #B was reviewed on 1/6/11 at 10:45 a.m. Diagnoses for Resident #B included, but were not limited to, dementia, delusions, and incontinence. A care plan for wandering was dated 9/29/10. A second care plan for incontinence was dated as 7/8/10. The care plans had not been reviewed, revised or updated since. 4. The record of Resident #117 was reviewed on 1/3/2011 at 3:00 PM. Diagnoses for Resident #117 included, but were not limited to, Heat Syncope (fainting due to heat related stress on the body), Anemia, Hypertension, Hypothyroidism, Severe Bilateral Carotid Stenosis. A health care plan problem dated 2/10/2010, indicated Resident #117 had a history of falling related to diagnosis of Heat Syncope. The goal of the care plan was, Resident will remain free from injury. The care plan indicated that there	F 279	needs associated with a new resident admission. MDS Coordinators and other interdisciplinary team members, in conjunction with MDS 3.0 scheduled assessments, will construct, review, and update each resident's plan of care reflective of the resident's physician orders, triggered areas, and individualized/prioritized needs. III. The systemic change includes that each resident's plan of care specific to new physician orders will be reviewed and updated on daily (Monday-Friday) basis by Unit Managers and/or interdisciplinary team member. In addition, any Comprehensive MDS Assessment will include review of current plan of care (problem statement, goals, and interventions) for needed revisions or additions.	

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F 279	Continued From page 9 was an expected date to reach the goal set as 5/10/2010. The care plan had not been reviewed, revised or updated since the expected goal date. A health care plan problem dated 1/21/2010, indicated Resident #117 was at risk for skin breakdown related to frequent skin tears. The goal of the care plan was, Resident's skin will remain intact,and a statement stating "(last skin tear noted 7/26/09)." The care plan indicated that there was an expected date to reach the goal set as 4/21/10. The care plan had not been reviewed, revised or updated since the expected goal date. 5. Record review for Resident #66 was reviewed on 1/5/2011 at 3:30 PM. Diagnosis for Resident # 66 included, but were not limited to, depression. A health care plan problem dated 5/28/2010, indicated that resident makes repetitive questions about medications, family, care and roommate. The goal of the care plan is, resident will respond to others without asking repetitive questions. The care plan indicates that there is an expected date to reach the goal set as 8/28/10. The care plan has not been reviewed, revised or updated since the expected goal date. A health care plan problem dated 5/28/10, indicated that resident experiences crying with tearfulness at times. The goal of the care plain was, "resident will respond to others without crying, tearfulness." The care plan indicated that there was an expected date to reach the goal set as of 8/28/10. The care plan had not been reviewed, revised or updated since the expected	F 279	Training will be provided to all clinical interdisciplinary department manager personnel regarding construction and updating of comprehensive care plans. IV. Director of Nursing and/or designee will audit 10 resident charts plan of care (who is from sample of new admissions, comprehensive assessments, or new physician orders) on weekly basis for a total of six months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion Date: February 6, 2011.	

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F 279	Continued From page 10 goal date. 6. Record review for Resident #104 was reviewed on 1/4/2011 at 11:30 am. Diagnoses for Resident # 104 included, but were not limited to, psychosis, senile, edema, weakness, dementia, hypertension, type II diabetes mellitus, end stage renal disease, and hypothyroidism. A health care plan problem, not dated, indicated that resident required a therapeutic diet of NCS (no concentrated sweets) and NAS (no added salt). The goal of the care plan was, " resident weight will remain stable thru next review." The care plan indicated that there was an expected date to reach the goal set as of 7/19/10. The care plan had not been reviewed, revised or updated since the expected goal date. A health care plan problem, not dated, indicated that resident was at risk for falls due to weakness and decreased mobility. The goal of the care was, "resident free of falls resulting in serious injury through next review. " The care plan indicated that there was an expected date to reach the goal set as of 7/19/10. The care plan had not been reviewed, revised or updated since the expected goal date. During an interview with MDS Coordinator #1, on 1/5/11 at 4:55 p.m., she indicated, "Care plans get a review date written on them and a goal date is three months, or 92 days, from that date." 3.1-35(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 279 F 282	F282-483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN I. Resident #82, #104, #39's plan of care has been reviewed and updated as deemed necessary. A dialysis aftercare flow sheet assessment has been instituted for Resident #82. LPN #3 has received training regarding dressing change policy and procedure and completed dressing change competency observation. Resident #39's treatment administration record was corrected January 06, 2011. II. A hemodialysis aftercare assessment flow sheet has been initiated for all current residents receiving hemodialysis to document daily fistula/shunt/or dialysis catheter care (monitoring for symptoms of bleeding and infection).	

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F 282 SS=D	Continued From page 11 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure care plans were being followed for dialysis, wound care and pressure ulcer prevention for 3 of 21 residents reviewed for their care plans being followed in a sample of 24. (Residents #82, #104 and #39) Findings included: 1. The record of Resident #82 was reviewed on 1/6/11 at 8:10 A.M. Diagnoses for Resident #82 included, but were not limited to, end stage renal disease and dialysis. She was admitted to the facility on 5/21/10 and had been receiving dialysis treatments at a local dialysis center on Monday, Wednesday and Friday every week since her admission. A care plan for Resident #82, originating on 5/26/10 and updated 9/16/10, indicated a problem of "Dialysis related to chronic renal failure" and a goal of "Will have no adverse reactions to dialysis process through next review." Approaches/interventions included, but were not limited to: ..."3 Monitor I & O [intake and output]/record...6 Observe shunt site daily for	F 282	Licensed Nurses have received training regarding dressing change policy and procedure and completed a dressing change competency observation. All residents who have skin care treatments physician orders, treatment administration record, and plan of care have been reviewed. III. A systemic change will include the development and implementation of a hemodialysis aftercare flow sheet. The hemodialysis aftercare flow sheet will be completed every shift by the licensed nurse caring for each residents receiving hemodialysis. Staff Development Coordinator and/or designee will observe four scheduled resident dressing/skin care treatments per week.	

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	155327	A. BUILDING _____ B. WING _____	C 01/07/2011

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F 282	Continued From page 12 signs and symptoms of infection and bleeding...8 Monitor site for signs of bleeding when returns from dialysis..." A "Vitals Report", received on 1/7/11 at 10:45 from the Assistant Director of Nursing (ADON) indicated the amount of fluid intake in cubic centimeters (cc's) Resident #82 drank daily in November, December, 2010, and January 3 - 7, 2011. There were no specific amounts of urine output documented on these days. Urine output was only measured as "small," "medium" or "large." Nurses' notes for Resident #82 for November, December, 2010 and January, 2011 did not indicate her shunt site was ever observed for signs of infection. They did not indicate the shunt site was observed for signs of bleeding on November 1 - 29, 2010, December 2 - 8, 11-13, 15, 18, and 28, 2010, and January 2 - 4, 2011. Nurses' notes for November, December, 2010 and January, 2011 did not indicate the shunt site was monitored for signs of bleeding after Resident #82 returned from dialysis on November 3, 5, 8, 10, 12, 15, 17, 19, 22, 24, 26, and 29, 2010, December 3, 6, 8, 13, 15, 2010, and January 3 and 5, 2011. Further information was requested from Licensed Practical Nurse (LPN) #5 on 1/7/11 at 1:00 P.M. regarding the missing urine output measurements and assessments of the shunt site for infection and bleeding. On 1/7/11 at 4:00 P.M. LPN #5 indicated no further information was available which indicated assessments of the the resident's shunt site for	F 282	Unit Managers and/or designee will review dressing change physician orders, treatment administration record and plan of care for applicable residents weekly. Training will provided to licensed nurses regarding hemodialysis aftercare. This training will include review of assessment and documentation requirements of hemodialysis aftercare assessment flow sheet. Additionally, training has been provided to licensed staff regarding dressing change procedures and new admission and monthly physician order rewrite processes. IV. The Director of Nursing and/or designee will review 100% hemodialysis aftercare flow sheets weekly for six months.	

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F 282	Continued From page 13 bleeding and infection were done or the resident's urine output was measured. 2. The record of Resident # 104 was reviewed on 1/3/10 at 3:00 p.m. Diagnoses for Resident #104 included, but were not limited to, psychosis, senile, edema, weakness, dementia, hypertension, Type II diabetes mellitus, end stage renal disease, chronic obstructive pulmonary disease), hypothyroidism. A facility policy, dated June, 2005, titled "Dressings, Dry/Clean" stated " Verify that there is a physician's order for this procedure" and " Review the residents care plan, current order's, ..." A physician's order, dated 1/4/2011, indicated " apply Santyl ointment to rt [right] heal wound bed after cleaning with normal saline, apply Calmoderm to peri wound edges, apply foam dressing and wrap with Kerlix, change daily and prn soilage or dislodgement. " During an observation on 1/4/10 at 11:00 a.m., the resident was in bed with a "heels up" device placed under her lower extremities. LPN #3 started to perform the dressing change. He was being instructed by LPN #4 , the Staff Development Coordinator. After removing the old dressing, LPN #3 cleansed the wound by taking a plastic vial of normal saline solution and squirting it on the tissue outside of the wound in a manner allowing any bacteria around the wound to fall into the wound, as the saline did. LPN #3 then took a clean 4 x 4 piece of sterile gauze and patted the area dry. Next LPN #3 applied Calmoderm ointment (rather than Santyl, as the physician	F 282	Staff Development will observe four scheduled resident dressing/skin care treatments per week for six months. Unit Managers and/or designee will review dressing change physician orders, treatment administration record and plan of care for all residents weekly for six months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion date: February 6, 2011.	

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F 282	Continued From page 14 ordered) to the wound bed. He was then stopped by LPN #4 who stated that "the entire thing will need to be cleaned and started over." 2. The record of Resident #39 was reviewed on 1/6/2011 at 10:00 a.m. Diagnoses for Resident #39 included, but were not limited to, hypertension, chronic obstructive pulmonary disease), dementia, pulmonary fibrosis, diverticulitis and anemia. A recapitulated for physicians order for January, 2010, with an original date of 12/26/2010, indicated "apply bacitracin and cover R[ight] outer ankle wound with Telfa and tape at 9 am and remove at 9 p.m., open to air, no sock on R[ight] foot at night until healed." The record review indicated that the order was on the treatment sheet for this resident in the month of December, from 12/26/10 when it was written, and was signed off on the treatment sheet until 12/31/10. The treatment sheet for January 2011 did not have this order written on it. During an Interview with Unit Manager # 7 she indicated that the facility failed to transfer the order from 12/26/2010 to the January treatment sheets and that the treatment had not been performed on the resident since the last day of December, 2010.	F 282		
F 314 SS=D	3.1-35(g)(2) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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F 314	Continued From page 15 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure necessary treatment was provided to promote the healing of pressure sores for 2 of 4 residents reviewed for receiving treatment for pressure sores in a sample of 24/ (Residents #104 and #39) Findings included: A facility policy, dated June, 2005, titled "Dressings, Dry/Clean" stated " Verify that there is a physician's order for this procedure" and " Review the residents care plan, current order's, ..." 1. The record of Resident #104 was reviewed on 1/3/10 at 3:00 p.m. Diagnoses for Resident #104 included, but were not limited to, psychosis, senile, edema, weakness, dementia, hypertension, Type II diabetes mellitus, end stage renal disease, chronic obstructive pulmonary disease), hypothyroidism. A physician's order, dated 1/4/2011, indicated " apply Santyl ointment to rt [right] heal wound bed after cleaning with normal saline, apply	F 314	F314-483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES I. LPN#3 has received training regarding dressing change policy and procedure and completed a dressing change competency observation. Resident #39's treatment administration record was corrected January 07, 2011. II. Licensed Nurses have received training regarding dressing change policy and procedure and completed a dressing change competency observation. All residents who have skin care treatment physician orders, treatment administration record, and plan of care reviewed.	

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F 314	Continued From page 16 Calmoderm to peri wound edges, apply foam dressing and wrap with Kerlix, change daily and prn soilage or dislodgement. " During an observation on 1/4/10 at 11:00 a.m., the resident was in bed with a "heels up" device placed under her lower extremities. LPN #3 started to perform the dressing change. He was being instructed by LPN #4, the Staff Development Coordinator. After removing the old dressing, LPN #3 cleansed the wound by taking a plastic vial of normal saline solution and squirting it on the tissue outside of the wound in a manner allowing any bacteria around the wound to fall into the wound, as the saline did. LPN #3 then took a clean 4 x 4 piece of sterile gauze and patted the area dry. Next LPN #3 applied Calmoderm ointment (rather than Santyl, as the physician ordered) to the wound bed. He was then stopped by LPN #4 who stated that "the entire thing will need to be cleaned and started over." 2. The record of Resident #39 was reviewed on 1/6/2011 at 10:00 a.m. Diagnoses for Resident #39 included, but were not limited to, hypertension, chronic obstructive pulmonary disease), dementia, pulmonary fibrosis, diverticulitis and anemia. A recapitulated for physicians order for January, 2010, with an original date of 12/26/2010, indicated "apply bacitracin and cover R[ight] outer ankle wound with Telfa and tape at 9 am and remove at 9 p.m., open to air, no sock on R[ight] foot at night until healed." The record review indicated that the order was on the treatment sheet for this resident in the month	F 314	III. A systemic change will include Staff Development Coordinator and/or designee will observe four scheduled resident dressing/skin care treatments per week. Unit Managers and/or designee will review dressing change physician orders, treatment administration record, and plan of care for applicable residents weekly. Training will be provided to licensed nurses regarding dressing change procedures and new admission, monthly physician order rewrite processes. IV. The Director of Nursing and/or designee will oversee that Staff Development Coordinator will observe four scheduled resident dressing/skin care treatments per week for six months.	

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F 314	Continued From page 17 of December, from 12/26/10 when it was written, and was signed off on the treatment sheet until 12/31/10. The treatment sheet for January 2011 did not have this order written on it. During an Interview with Unit Manager #7 she indicated that the facility failed to transfer the order from 12/26/2010 to the January treatment sheets and that the treatment had not been performed on the resident since the last day of December, 2010. 3.1-40(a)(2)	F 314	Unit Managers and/or designee will review dressing change physician orders, treatment administration record and plan of care for applicable residents weekly for six months. Any identified concerns will be addressed.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to insure a resident with urinary incontinence was cleaned properly while receiving perineal care to prevent a potential urinary tract infection for 1 of 2 residents observed for receiving proper pericare in a sample of 24. (Resident #104)	F 315	The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion date: February 6, 2011.	

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F 315	Continued From page 18 Findings included: A facility policy with a date of September, 2005, received from the Assistant director of Nursing on 1/6/11 at 9:45 a.m., titled " Perineal Care", indicated for female residents.... "wash perineal area, wiping from front to back".... "separate labia and wash area downward from front to back..." Diagnosis for Resident #104 included, but were not limited to, psychosis, edema, senile, weakness, dementia, hypertension, end stage renal disease, chronic obstructive pulmonary disease and hypothyroidism. A minimal data set (MDS) dated on 12/10/10 reflects that resident is frequently incontinent of bowel and bladder and requires extensive assistance of 2 or more people for hygrine and bathing needs. During an observation of Perineal Care on 1/5/10 at 11:45 a.m., Certified Nursing Assistant (CNA) #12, who was being instructed by LPN #4, the Staff Development Coordinator, prepared needed supplies, washed her hands properly, prepared wash cloths, laid the wash cloths on the pad under the resident, put clean gloves on her hands, and started to clean resident. The CNA started to clean the middle of the perineal area (this would be the area behind the vagina and before the rectum) and then proceeding to go in a circular motion towards the front of the perineal area. The CNA was stopped by LPN #4 who stated "You need to wipe only from front to back, get a new towel and start from front to back."	F 315	F315-483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER I. C.N.A. #12 has received training regarding perineal care policy and procedure; and perineal care competency observation. II. C.N.A.'s have received training regarding perineal care policy and procedure; and perineal care competency observations. III. A systemic change will include the Staff Development and/or designee will observe six C.N.A.'s perform perineal care each week. Additionally, C.N.A.'s have been provided perineal care training and completed competency observations.	
F 323	3.1-41(a)(2) 483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 19 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that resident environment remain as free of accident hazards as possible on 4 of 8 resident rooms, in that; water temperatures exceeded 120 degrees Fahrenheit. (resident room, 206, 210, 105, & 109) Finding included: During the environmental tour on 1-6-11 at 2:00 p.m., with the Maintenance Supervisor, Housekeeping/Laundry Supervisor and Assistant, the following water temperatures were taken with a digital thermometer in hand washing sinks: 1. Resident Room # 206 - 130 degrees Fahrenheit Resident Room # 210 - 124 degrees Fahrenheit Resident Room # 105 - 129 degrees Fahrenheit Resident Room # 109 - 125 degrees Fahrenheit All temperatures were verified by Maintenance Supervisor and Housekeeper/Laundry Supervisor	F 323	IV. The Director of Nursing and/or designee will oversee the Staff Development Coordinator and/or designee will observe six C.N.A.'s performing perineal care weekly for six months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion date: February 6, 2011.	

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F 323	Continued From page 20 at the time they were taken. During interview at that time the Maintenance Supervisor indicated the facility had two hot water heaters. One controls the 100, 200, 300, & 400 corridors, the second water heater controls 500, 600, 700, & 800 corridors. He also indicated he was unaware of any problems that would cause the current, unusually high, water temperatures . He indicated the temperatures were not consistently above 120 degrees during facility monitoring. The Administrator was advise of the high water temperatures on 1-6-11 at 5:00 p.m.. The environmental tour was suspended at this time. No showers were given and residents were advised to be sure to add cold water to the hot water and signs were posted above hand sinks in each resident room while staff worked to correct the problem. The water temperatures were retested on 1-6-11 at 7:15 p.m. with the Maintenance Supervisor. The following water temperatures were taken by a digital thermometer: 2. Resident Room # 105 - 110 degrees Fahrenheit Resident Room # 109 - 109 degrees Fahrenheit Resident Room # 206 - 109 degrees Fahrenheit Resident Room # 210 - 109 degrees Fahrenheit Resident Room # 302 - 116 degrees Fahrenheit Resident Room # 407- 118 degrees Fahrenheit All temperatures were verified by Maintenance Supervisor at the time they were taken. 3.1-45(a)(l)	F 323	F 323-483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES I. Resident room #206; #210; #105; #109 water temperatures were corrected 1-6-11. Mixing valves x2 were replaced. II. Resident room #210; #410; #608; #810; East & West shower room water temperatures were checked 1-8-11 were within acceptable range. Resident room #111; #114; #207; #210; #315; #415; #415; #511; #610; #609; #715; #710; #810; #813; East and West shower room water temperatures were checked 1-9-11 and were within acceptable range.	

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F 323	Continued From page 21	F 323	III. A systemic change will include that the Maintenance Department will increase water temperature checks from weekly to three times weekly to include 10 locations. Training will be provided to all staff to report any signs of water temperature variations (too cold or hot) to maintenance, department manager immediately. IV. Administrator and/or designee will audit water temperature recordkeeping weekly for six months. Any identified concerns will be addressed.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		

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F 329	Continued From page 22 by: Based on record review and interview the facility failed to ensure that alternate measures were used prior to the administration of medication and document the effectiveness of given PRN medication for 2 out of 24 residents sampled during the survey. (Residents #111, #131) Findings included: 1. The record review for Resident #111 was reviewed on 1/4/11 at 1:55 p.m. Diagnoses for Resident #111 included but not limited to atrial fibrillation, coronary artery disease, sick sinus syndrome with pacemaker placement, peripheral vascular disease, congestive heart failure, diabetes mellitus, acute brain stem cerebrovascular accident, hypertension, and benign prostatic hypertrophy. The facility's policy on PRN medication, reviewed on 1/5/11 at 9:20 a.m., indicated to record on the front and back of the medication administration record and shall include the result of the medication given. The recapitulated doctors for Resident #111 to receive ativan 1 milligram via peg tube every 8 hours PRN for anxiety with an original date of 11/19/2010. The cognitive status for Resident #111 on 11/27/2010 scored a 15 on the Bemis test indicating the resident had no problem with his long term or short term memory. The MDS [minimum data set] also indicated the resident usually understand and understood when being communicated with. The medication administrative record for Resident #111 indicated he received PRN ativan 1 milligram on the	F 329	The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion date: February 6, 2011.	

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F 329	Continued From page 23 following dates: November 20, 21, 23, 28, and 29. December 1, 2, 3, 4, 9, 21, and 22. There were no results documented on the back of the medication administration record or in the nursing notes indicating why these medications were given. There was no documentation indicating alternate measures were used prior to the administration of the medication. 2. The record review for Resident #131 was on 1/3/2011 at 3:10 p.m. Diagnoses for Resident #131 included but not limited to cerebral atrophy, cerebrovascular accident with right sided weakness, hypertension, generalized anxiety disorder, and osteoarthritis. The medication administration record for Resident #131 had the recapitulated doctors order to give ibuprofen 400 milligrams to give 1 tablet every 6 hours PRN for pain with an original order date of 9/17/2010. The medication administration record for Resident #131 indicated she received PRN ibuprofen 400 milligrams on December 25 in which no results of the medication was documented on the back of the medication administration record or in the nursing notes. There was no documentation indicating alternate measures were used prior to the administration of the medication. During an interview with Unit Manager #2 on 1/6/2011 at 4:30 p.m., in regards to the documentation of the effectiveness of the PRN medications, she indicated the effectiveness is charted on the back of the medication administration record then added that sometimes the nurses chart it in the nursing notes. She	F 329	F 329-483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS I. Resident # 111's anxiety plan of care was reviewed for appropriate alternative nursing measures to institute prior to administration of prn Ativan. Resident # 131's pain plan of care was reviewed for appropriate alternative nursing measures to institute prior to administration of prn ibuprofen. II. Unit Manager and/or designee are reviewing documentation of prn medication administration inclusive of alternate measures and effectiveness for residents on daily basis (Monday-Friday).	

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F 329	Continued From page 24 indicated in her interview that the facility does provide alternate measures prior to administration of the PRN medication. 3.1-48(a)	F 329	III. A systemic change will include that documentation of prn medication order on medication administration	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents with pharmacy recommendations were followed up with physician for 2 of 21 residents reviewed for pharmacy recommendations in a sample of 24. (Resident # 42 and #60.) Findings included: An undated facility policy, reviewed 1/6/11 at 3:55 p.m., titled "MEDICATION REGIMEN REVIEW FORM COMPLETION", indicated "The Medication Regimen Review (MRR)) form is to be completed as follows:...PHYSICIAN WILL: 1. Review recommendations made and either: a. Check the boxes next to approved orders. b. Write new orders or check "no new orders"...3.	F 428	record will include verbiage to document alternate measures trialed prior to administration of medication. Training will be provided to all licensed nurse personnel regarding facility policy on prn administration. IV. The Director of Nursing and/or designee will review prn medication administration documentation records on daily basis (Monday-Friday) for six months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be	

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F 428	Continued From page 25 Sign and date form." 1. Record review of Resident #42, on 1/4/11 at 2:10 p.m., indicated a physician's order on 2/2/10 for Lexapro 20 mg (anti-depressant) daily. A "(Vendor) Pharmacy Medication Plan of Care", dated 9/7/10, indicated a recommendation from the pharmacist for a Gradual Dose Reduction (GDR) on the Lexapro. During an interview with the vendor pharmacist, on 1/4/11 at 3:35 p.m., she indicated, "I requested a GDR for Lexapro in September 2010 and I have had no response." The Assistant Director of Nursing (ADON) indicated on 1/4/11 at 3:55 p.m., "Once pharmacy makes a GDR recommendation, the nurse notifies the doctor or places it on the doctors list for the next visit." The ADON indicated on 1/4/11 at 4:25 p.m., "It's not in here...But at this point, all we can do is call the doctor now." The record of Resident #60 was reviewed on 1/5/11 at 3:45 P.M. Diagnoses for Resident #60 included, but were not limited to, chronic renal insufficiency, paroxymal atrial fibrillation, psychoses. A "Skilled Care Pharmacy Medication Plan of Care," received from the Director of Nursing (DoN) on 1/6/11 at 8:30 A.M. indicated during the pharmacy medication review on 8/30/10, the pharmacist made a recommendation that Resident #60 receive an FLP (Fasting Lipid Profile), a lab draw, every 6 months. There was	F 428	adjusted as deemed necessary. Completion Date: February 6, 2011. F428-483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON I. Resident #42 and Resident #60's pharmacy recommendations were corrected. II. Director of Nursing has conferred with Consultant Pharmacists regarding any outstanding pharmacy recommendations which were not addressed by the physician.	

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F 428	Continued From page 26 no documentation in the resident's record to indicate this recommendation had been noted by the facility or the physician. Further information was requested from Director of Nursing (DoN) on 1/5/10 at 5:30 P.M. On 1/6/10 at 8:40 P.M. the DoN indicated the recommendation for the FLP made by the pharmacist on 8/30/10 had not been addressed. 3.1-25(j)	F 428	III. A systemic change will include the pharmacy recommendations will no longer be left in the medical record for physician review and signature. Facility personnel will provide the physician (in person) and/or fax and phone notification of pharmacy recommendations. IV. The Director of Nursing and/or designee will review 100% pharmacy recommendations for timely notation by the physician and facility for six months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion Date: February 6, 2011	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		

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F 441	Continued From page 27 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the nursing staff was following policy regarding cleaning a wound without contaminating the wound itself, in 1 of 3 residents observed for wound care in a sample of 21. (Resident #104) Findings include: The record for Resident # 104 was reviewed on 1/3/10 at 3:00 p.m. Diagnoses for Resident # 104 included, but were not limited to, psychosis, senile, edema, weakness, dementia, hypertension, type II diabetes mellitus, end stage renal disease, chronic obstructive pulmonary disease) and hypothyroidism. A facility policy, dated June, 2005, titled "Dressings, Dry/Clean," indicated "...Cleanse the wound...Clean from the least contaminated area to the most contaminated area (usually, from the center outward)..."	F 441	F441-483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS I. LPN #3 has received training regarding dressing change policy and procedure and completed a dressing change competency observation. II. Licensed Nurses have received training regarding dressing change policy and procedure and completed a dressing change competency observation. III. A systemic change will include the Staff Development Coordinator and/or designee will observe four scheduled resident dressing/skin care treatments per week.	

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F 441	Continued From page 28 A physicians order, dated 1/4/2011, indicated "apply Santyl ointment to rt [right] heal wound bed after cleaning with normal saline..." During an observation on 1/4/10 at 11:00 a.m., the resident was in bed with a "heels up" device placed under her lower extremities. LPN # 3 started to perform the dressing change. He was being instructed by LPN # 4 , the Staff Development Coordinator. After removing the old dressing, LPN # 3 cleansed the wound by taking a plastic vial of normal saline solution and squirting it on the tissue outside of the wound in a manner allowing any bacteria around the wound to fall into the wound, as the saline did. LPN # 3 then took a clean 4 x 4 piece of sterile gauze and patted the area dry. LPN # 3 was then stopped by LPN # 4 who stated that "the entire thing will need to be cleaned and started over."	F 441	IV. The Director of Nursing and/or designee will monitor results of Staff Development observations four scheduled resident dressing/skin care treatments per week for six months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the plan will be adjusted as deemed necessary. Completion date: February 6, 2011.	
F 502 SS=D	3.1-18(j) 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to obtain laboratory services in a timely manner for 1 of 21 residents reviewed for timely laboratory services in a sample of 24. (Residents #104)	F 502		

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F 502	Continued From page 29 Findings included: 1. The record for Resident #104 was reviewed on 1/3/2010 at 3:00 p.m. Resident #104 diagnoses included, but were not limited to, psychosis, senile, edema, weakness, dementia, hypertension, type II diabetes mellitus, end stage renal disease, chronic obstructive pulmonary disease and hypothyroidism. A physician's order dated 10/28/10, indicated Resident # 104 was to have a TSH in 6 weeks. This lab would give the Thyroid Stimulating Hormone level in the blood, making staff and doctor aware of Thyroid function. There were no lab results in Resident #104's record for this TSH lab draw which would have been due on or around December 9 th. During interview with the DON (Director of Nursing) on 1/4/2011 at 1:00 p.m., she indicated the lab draw was not done and she would call the laboratory for a "stat" (refers to something that needs done immediately) lab draw for this resident. At 5:00 p.m. on 1/4/2011 the DON brought the results of the lab draw indicating that the results of the TSH lab were normal and that the doctor had been notified.	F 502	F502-483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY I. Resident #104 TSH lab draw was completed 1/4/11. II. 100% current resident charts have been reviewed. The focus of review was to reconcile physician orders with Greenwood Laboratory master list and verify lab completion. III. A systemic change will include implementation of a new lab services procedure which addresses lab orders; communication with lab and physician; tracking system; and auditing.	
F 507 SS=D	3.1-49(a) 483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	F 507		

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F 507	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the results of a laboratory test were filed in a resident's record for 1 of 21 residents reviewed for having results of lab tests in their records in a sample of 24. (Resident #146) Findings included: The record of Resident # 146 was reviewed on 1/4/2011 at 1:30 p.m. Resident # 146 diagnoses included, but were not limited to, subarachnoid hemorraghic (bleeding in the brain), hypertension, benign prostatic hypertension (narrowing of the prostate), restless leg syndrome, hypothyroidism, renal stones and Parkinson's disease. A physician's order for a lab draw, dated 12/14/10, indicated "Iron Studies x 1." Review of the lab reports revealed that this lab, ordered 12/14/10, was drawn by the laboratory on 12/15/10, but the facility did not obtain a copy of the results and one was never sent to them from the laboratory. During an interview with the DON on 1/4/2011 at 4:00 p.m., she indicated they were able to call the laboratory and get a copy of the study that was done. Observation of copy of this report reflects abnormal results and it was called into the doctor's office on 1/4/2011 at 6:00 p.m.	F 507	Training will be provided to Licensed Nurses and Nursing Management Personnel regarding new lab services procedure. IV. The Director of Nursing and/or designee will audit 10 resident charts to evaluate accuracy, timeliness and completion of laboratory orders weekly for six months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion Date: February 6, 2011.	

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F 507 F 514 SS=D	Continued From page 31 3.1-49(f)(4) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure care was documented for residents with a Foley catheter, pressure relieving boots and a resident needing assistance with a shower or bath for 3 out of 21 residents reviewed for complete and accurate clinical records in a sample of 24. (Residents #111, #30 and #A) Findings included: 1. The record of Resident #111 was reviewed on 1/4/11 at 1:55 p.m. Diagnoses for Resident #111 included, but were not limited to, atrial fibrillation, coronary artery disease, sick sinus syndrome with pacemaker placement, peripheral vascular disease, congestive heart failure, diabetes mellitus, acute	F 507 F 514	F507-483.75(j)(2)(iv) LAB REPORTS IN RECORD-LAB NAME/ADDRESS I. Resident #146 Iron Study lab results were communicated to physician 1/4/11. II. 100% current resident charts have been reviewed. The focus of review was to reconcile physician orders with Greenwood Laboratory master list and verify lab completion and physician communication. III. A systemic change will include implementation of a new lab services procedure which addresses on lab orders; communication with lab and physician; tracking system; and auditing.	

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F 514	Continued From page 32 brain stem cerebrovascular accident, hypertension, and benign prostatic hypertrophy. Resident #111 had a urinary catheter since his admission on 11/17/2010. The care plan for urinary catheter dated 12/16/2010 with a review date of 3/16/2011, indicated to provide catheter care and to document the care given every shift. There was no documentation in the resident's printed clinical record or the electronic clinical record showing the care was provided. During an interview with employee #2 on 1/5/2011 at 4:45 p.m., in regards to the catheter care on Resident #111's, she indicated no documentation on the catheter care was done but she knew the care was done when the resident got his peri care every shift. 2. The printed clinical record of Resident # 30 was reviewed on 1-3-2011 at 3:30 p.m. Diagnoses for Resident # 30 included, but were not limited to, subarachnoid hemorrhage, left side hemiplegia, osteopenia, chronic pain, mild vascular dementia, arteriosclerosis of lower extremities and history of fracture. A physician's order, dated 3-17-10, indicated that Prevalon boots were to be placed on the feet of Resident # 30 while in bed, on at 9:00 p.m. and off at 7:00 a.m. A health care plan problem, dated 9-25-08 and updated 7-14-10, indicated Resident # 30 was at risk for pressure ulcers related to decreased mobility due to cerebral vascular accident [stroke] with left hemiparesis, left arm	F 514	Training will be provided to Licensed Nurses and Nursing Management Personnel regarding new lab services procedure. IV. The Director of Nursing and/or designee will audit 10 resident charts to evaluate accuracy, timeliness and completion of laboratory orders weekly for six months. Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion Date: February 6, 2011.	

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F 514	Continued From page 33 contractures, bowel and bladder incontinence and osteoarthritis. One approach for this problem was for the staff to apply "Prevalon boots while in bed on at 9:00 p.m. off at 7:00 a.m." Nurses notes, dated 11-1-10 through 1-6-11, did not include any documentation indicating that the Prevalon boots were placed on or removed from the feet of Resident # 30. A Treatment Administration Record (TAR) for January, 2011, indicated that the Prevalon boots for Resident # 30 were not recorded as being removed at 7:00 a.m. for the dates of January, 1 and 2. A TAR for December, 2010, indicated that the Prevalon boots were not placed on the feet of Resident # 30 at 9:00 p.m. for the dates of December 2, 3, 6, 11, 13, 16, 21, 22, 24, 26, 27, 28, 29, 30 and 31. The same TAR for December, 2010, indicated that the Prevalon boots were not removed from the feet of Resident # 30 at 7:00 a.m. for the dates of December 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 24, 25, 26, 27, 29, 30 and 31. A TAR for November, 2010, indicated that the Prevalon boots were not placed on the feet of Resident # 30 at 9:00 p.m. for the dates of November 1, 2, 3, 5, 8, 9, 10, 13, 15, 17, 18, 19, 20, 22, 23, 27, 28 and 29. The same TAR for November, 2010, indicated that the Prevalon boots were not removed from the feet of Resident # 30 at 7:00 a.m. for the dates of November 1, 2, 3, 6, 7, 11, 15, 16, 17, 20, 21, 24, 26, 27, 28 and 29. During an interview with the Assistant Director of Nursing (ADON) on 1-5-2011 at 11:40 a.m., the TARs for the months of January, 2011, December, 2010 and November, 2010 were reviewed by the ADON and she indicated there	F 514	F514-483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE I. Resident #111 Foley catheter care is documented on an ADL flow sheet. Medical Records is auditing treatment administration records for completeness of documentation Resident #30's pressure relieving boots. Resident #A's bathing is recorded on an ADL flow sheet. II. An ADL flow sheet was created for catheter care documentation—audits for all residents with indwelling or suprapubic catheters are audited daily (Monday-Friday). Unit Manager and/or designee have audited bathing documentation for all current residents. Medical Records has audited all current treatment	

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F 514	Continued From page 34 was probably no additional documentation indicating that the Prevalon boots were being placed on and removed from the feet of Resident # 30. The ADON stated that the aides were responsible for placing and removing the Prevalon boots. During an interview with the ADON on 1-6-2011 at 9:20 a.m., the ADON indicated that the TAR is signed off by the nurses after the aides communicate to the nurses that the Prevalon boots have been taken off or put on the Resident's feet. 3. The record of Resident #A was reviewed on 1/7/11 at 12:00 p.m. Diagnoses for Resident #A included, but were not limited to, depression, obsessive-compulsive disorder, history of left hip fracture and compression fracture of back. During an interview with the Director of Nursing (DoN) on 1/7/10 at 2:30 p.m. she indicated the facility did not have a shower policy but showers were supposed to be offered 2 times per week and if the resident refused a shower a bed bath could be given instead. She indicated a Shower Sheet is filled out each time a shower or bath is offered to a resident. During an interview with Resident #A's daughter on 1/7/11 at 12:15 p.m. she indicated she didn't think the resident was getting enough baths because she "smelled bad." Resident A's Shower Sheets for October, November and December, 2010 and January, 2011, received from the Assistant Director of	F 514	administration records for completeness of documentation. III. A systemic change will include development and initiation of ADL flow sheet; comprehensive auditing schedule for ADL flow sheets; bathing completion and treatment administration records. Training will be provided to Licensed Nurses and C.N.A.'s to review ADL flow sheet, bathing, and treatment administration documentation. IV. The Director of Nursing and/or designee will audit 10 resident charts to check completeness of catheter care, treatment administration records, and bathing documentation weekly for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155327	A. BUILDING _____ B. WING _____	C 01/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 35 Nursing on 1/7/11 at 3:30 p.m. indicated: 10/8/10: resident refused 10/15/10: resident refused 10/22/10: bed bath given 10/26/10: resident refused 10/29/10: bed bath given 11/5/10: resident refused 11/12/10: bed bath given 11/19/10: bed bath given 11/26/10: bed bath given 12/3/10: resident refused 12/17/10: resident refused 12/21/10: form had resident's name but no other information 12/28/10: bed bath 12/31/10: bed bath given 1/4/10: bed bath given These forms indicated Resident #A was offered a shower or bed bath only 5 times in October, 2010, 4 times in November, 2010 and 5 times in December, 2010. This federal tag relates to complaint number IN00084479. 3.1-50(a)(1)	F 514	Any identified concerns will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting. Modifications of the following plan will be adjusted as deemed necessary. Completion Date: February 6, 2011.	